Request for Trauma Registry Database Information

Person/Agency Requesting Information			
Name:			
Agency Name (if applicable):			
Phone:	Fax:	E-mail:	
City:	State:	Zip:	
Do you prefer your results to be on ***paper,*** or sent by ***email*** (circle one): Address to send results to:			

Statement of Information Requested
Please state the information you are requesting. Remember to include a time period and to reference the trauma database categories to increase the effectiveness of your request

Disclaimer
All requests are subject to approval from the Office of Emergency Medical Services and must follow all established protocols of the Virginia Department of Health. All requests are handled on a 'first come, first served' basis. Data analysis is limited to the accuracy of the data submitted to the database. Less then optimal data submissions minimize the strength of the data and subsequent analysis. Therefore these numbers can neither be considered exact or substantiated.
Date:
Signature:

Please fill out the request form as completely as possible and send to:

Carolyn Halbert M.A, M.P.H.
Office of Emergency Medical Services
109 Governor Street Suite UB 55
Richmond Virginia 23219
Fax: 804 864 7580
Phone 804 864 7600

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